

2003

JCAHO

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Clinical Center JCAHO Work Group

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Medical Record Department Reminders

Access to Medical Records

- NIH employees may have access or request access to medical records if required to accomplish their assigned duties.
- Other individuals or institutions may have access to medical records according to the specific written authorization of the patient.



Release of Medical Information

- Requests for release of medical information, authorized by the patient, should be forwarded promptly to the MRD's Medicolegal Section (10/1N216) for processing. Such authorizations should be complete, with patient signature and the address of the requested recipient of the records.
- The MRD forwards copies of dictated inpatient discharge summaries to physicians listed in MIS to receive reports as identified by the patient upon completion.



General Medical Record Documentation Requirements

- All handwritten entries must be written LEGIBLY.
- All entries must be dated and signed.
- Incomplete medical records must be dictated and signed within 30 days of the outpatient visit or inpatient discharge before they become delinquent.
- Patient name and medical record number must be included on all documentation to be filed in the medical record.
- All forms must be reviewed and approved by the Medical Record Committee (contact the MRD on 496-2292 to obtain further guidance on form development/design).

Authentication Requirements

- All entries in the medical record should be signed, with full name and professional designation, and dated.

To ask questions of the Clinical Center core group, email: askCCJCAHO@cc.clinicalcenter.nih.gov
Clinical Center Website: <http://intranet.cc.nih.gov/cconly/od/jcaho/>



- Initials should not be used in lieu of full signature unless previously approved and interpretation identifying the author is supplied.
- Signature stamps are NOT approved for use in the Clinical Center.

See other side→

History and Physical Exams

All H&P's must be performed and documented (*including date and time*) within 24 hours of an inpatient admission.

Operative Reports

- All operative procedures performed in the OR must be dictated the same day as the surgery.
- A note must be written in the progress notes of the medical record, immediately post op by the surgeon. Minimally the content must include the names of the primary surgeon, assistants, findings, technical procedures used, specimens removed and the post operative diagnosis. This note must be dated, timed and signed.



Medical Record Maintenance

- For *inpatient admissions*, all parts of the medical record must be returned to the Record Management Section (10/1N211) within 48 hours following discharge.
- For *outpatient visits*, all parts of the medical record must be returned to the Record Management Section (10/1N211) within 24 hours of the last scheduled appointment.
- ***It is important that records are returned promptly to the MRD so they are available for future patient care encounters.***
- Medical records transported by or with a patient are to be placed in a blue transport bag and secured with a plastic locking device.

Other Medical Record Department Services

The MRD has a Privacy Act Compliance Committee, which visits areas within the Clinical Center to assure compliance with confidentiality standards. This group is available to visit any area in the Clinical Center at any time. For further information or to coordinate a review, contact the MRD on 496-2292.



The Medical Record Handbook is available through the CC webpage at:

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<http://www.cc.nih.gov/ccc/mrh/Default.htm>

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